

1 XAVIER BECERRA
Attorney General of California
2 JANE ZACK SIMON
Supervising Deputy Attorney General
3 REBECCA D. WAGNER
Deputy Attorney General
4 State Bar No. 165468
455 Golden Gate Avenue, Suite 11000
5 San Francisco, CA 94102-7004
Telephone: (415) 510-3760
6 Facsimile: (415) 703-5480
E-mail: Rebecca.Wagner@doj.ca.gov
7 *Attorneys for Complainant*

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9 **BEFORE THE**
MEDICAL BOARD OF CALIFORNIA
10 **DEPARTMENT OF CONSUMER AFFAIRS**
11 **STATE OF CALIFORNIA**

12
13 In the Matter of the Accusation Against:

Case No. 800-2017-035909

14 **Philipp Leo Bannwart, M.D.**
15 **BAHNHOFPLATZ 6**
16 **3920 ZERMATT 99**
17 **Switzerland**

A C C U S A T I O N

18 **Physician's and Surgeon's Certificate**
19 **No. A 83871,**

20 Respondent.

21 Complainant alleges:

22 **PARTIES**

23 1. Kimberly Kirchmeyer (Complainant) brings this Accusation solely in her official
24 capacity as the Executive Director of the Medical Board of California, Department of Consumer
25 Affairs (Board).

26 2. On or about July 2, 2003, the Medical Board issued Physician's and Surgeon's
27 Certificate Number A 83871 to Philipp Leo Bannwart, M.D. (Respondent). The Physician's and
28

1 Surgeon's Certificate was in full force and effect at all times relevant to the charges brought
2 herein and will expire on February 28, 2019, unless renewed.

3 JURISDICTION

4 3. This Accusation is brought before the Board, under the authority of the following
5 laws. All section references are to the Business and Professions Code unless otherwise indicated.

6 4. Section 2004 of the Code states:

7 "The board shall have the responsibility for the following:

8 "(a) The enforcement of the disciplinary and criminal provisions of the Medical Practice
9 Act.

10 "(b) The administration and hearing of disciplinary actions.

11 "(c) Carrying out disciplinary actions appropriate to findings made by a panel or an
12 administrative law judge.

13 "(d) Suspending, revoking, or otherwise limiting certificates after the conclusion of
14 disciplinary actions.

15 "(e) Reviewing the quality of medical practice carried out by physician and surgeon
16 certificate holders under the jurisdiction of the board.

17 "..."

18 5. Section 2227 of the Code states:

19 "(a) A licensee whose matter has been heard by an administrative law judge of the Medical
20 Quality Hearing Panel as designated in Section 11371 of the Government Code, or whose default
21 has been entered, and who is found guilty, or who has entered into a stipulation for disciplinary
22 action with the board, may, in accordance with the provisions of this chapter:

23 "(1) Have his or her license revoked upon order of the board.

24 "(2) Have his or her right to practice suspended for a period not to exceed one year upon
25 order of the board.

26 "(3) Be placed on probation and be required to pay the costs of probation monitoring upon
27 order of the board.

1 “(4) Be publicly reprimanded by the board. The public reprimand may include a
2 requirement that the licensee complete relevant educational courses approved by the board.

3 “(5) Have any other action taken in relation to discipline as part of an order of probation, as
4 the board or an administrative law judge may deem proper.

5 “(b) Any matter heard pursuant to subdivision (a), except for warning letters, medical
6 review or advisory conferences, professional competency examinations, continuing education
7 activities, and cost reimbursement associated therewith that are agreed to with the board and
8 successfully completed by the licensee, or other matters made confidential or privileged by
9 existing law, is deemed public, and shall be made available to the public by the board pursuant to
10 Section 803.1.”

11 6. Section 2234 of the Code, states, in relevant part:

12 “The board shall take action against any licensee who is charged with unprofessional
13 conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not
14 limited to, the following:

15 “(a) Violating or attempting to violate, directly or indirectly, assisting in or abetting the
16 violation of, or conspiring to violate any provision of this chapter.

17 “(b) Gross negligence.

18 “(c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or
19 omissions. An initial negligent act or omission followed by a separate and distinct departure from
20 the applicable standard of care shall constitute repeated negligent acts.

21 “(1) An initial negligent diagnosis followed by an act or omission medically appropriate for
22 that negligent diagnosis of the patient shall constitute a single negligent act.

23 “(2) When the standard of care requires a change in the diagnosis, act, or omission that
24 constitutes the negligent act described in paragraph (1), including, but not limited to, a
25 reevaluation of the diagnosis or a change in treatment, and the licensee’s conduct departs from the
26 applicable standard of care, each departure constitutes a separate and distinct breach of the
27 standard of care.

28 “(d) Incompetence.

1 “(e) The commission of any act involving dishonesty or corruption which is substantially
2 related to the qualifications, functions, or duties of a physician and surgeon.

3 “...“

4 7. Section 2242(a) of the Code states that prescribing, dispensing, or furnishing
5 dangerous drugs as defined in Section 4022¹ without an appropriate prior examination and a
6 medical indication, constitutes unprofessional conduct.

7 **BACKGROUND FACTS**

8 8. At all times relevant to this matter, Respondent was licensed and practicing medicine
9 in California.

10 9. Respondent treated, on an outpatient basis, Patient P-1² from July 21, 2011 to
11 February 1, 2012³. Patient P-1 was a 49 year old female, with a past medical history of poly-
12 substance abuse, post-traumatic stress disorder, bipolar disorder, chronic pain syndrome and a
13 history of overdose. Respondent prescribed multiple opioid medications to Patient P-1 including
14 methadone⁴, hydrocodone⁵ and codeine⁶. Over the course of five months, Respondent increased
15 Patient P-1's methadone from 60 milligrams per day to 200 milligrams per day, which has a
16 morphine milligram equivalent of 2400.⁷

17 10. On July 21, 2011, Patient P-1 was treated by Respondent at Concord Health Center
18 for chronic pain partially related to a fall from May 29, 2011 where she had been admitted at John

19 ¹ Dangerous drug means any drug unsafe for self-use in humans or animals including
20 drugs that require a prescription to be lawfully dispensed.

21 ² The patient is designated in this document as Patient P-1 to protect her privacy.
22 Respondent knows the name of the patient and can confirm her identity through discovery.

23 ³ The only medical records available are from this time period; however, Respondent may
24 have treated her longer than indicated in the medical records per his statements during the
25 investigation.

26 ⁴ Methadone is a synthetic narcotic analgesic with multiple actions quantitatively similar
27 to those of morphine. It is a dangerous drug as defined in section 4022 and a Schedule II
28 controlled substance. Methadone exhibits a non-linear relationship due to the long half-life and
accumulates with chronic dosing.

⁵ Hydrocodone is an opioid/narcotic pain reliever used to treat moderate to severe pain. It
is a dangerous drug as defined in section 4022 and a Schedule II controlled substance.

⁶ Codeine is an opioid analgesic used to treat mild to moderately severe pain. It is a
dangerous drug as defined in section 4022 and a Schedule II controlled substance.

⁷ Morphine milligram equivalency (also known as MME) is used to convert the many
different opioids into one standard value based on morphine and its potency. Oxycodone, for
example, is 1.5 times as potent as morphine so 100 milligrams of oxycodone is equivalent to 150
MME.

1 Muir Medical Center. Patient P-1 stated her pain was a 7 out of 10 and was generalized.

2 Respondent prescribed 180 pills of 10 milligrams of methadone to Patient P-1.

3 11. On August 10, 2011, Patient P-1 was treated again by Respondent for pain
4 management issues. Respondent noted in the chart that Patient P-1 was almost blind and he
5 referred her to Ophthalmology. Patient P-1 was prescribed 320 10 milligram pills of methadone
6 between Respondent (300 pills) and another physician (20 pills). The total methadone dosage per
7 day was 100 milligrams.

8 12. Respondent treated Patient P-1 again on September 1, 2011 for a follow-up visit and
9 Patient P-1 stated her pain was 9 out of 10 and was "uncontrolled" but that pain levels improved
10 on higher doses of methadone. She had run out of pain medication the day before and was
11 "withdrawing." On September 12, 2011, Patient P-1 called the Concord Health Center stating the
12 pharmacy would not fill her prescription because the dosage was increased. Patient P-1 returned
13 for follow-up on September 14, 2011 for medication as there was some difficulty getting her
14 methadone approved by insurance.

15 13. On October 5, 2011, Patient P-1 was treated by Respondent for a follow-up to get
16 methadone refilled and said it worked well with her pain.

17 14. In October and November 2011, Respondent prescribed 480 pills totaling 160
18 milligrams of methadone per day. In addition, Respondent prescribed 180 10 milligram
19 hydrocodone/acetaminophen pills totaling 60 milligrams per days (an MME of 60 per day).
20 Respondent also prescribed 480 milliliters of 10 milligram/5 milliliters codeine promethazine
21 syrup⁸ with an MME of 4.8 per day.

22 15. On December 19, 2011, Patient P-1 was seen by Respondent for follow-up and
23 medication refill after having been hospitalized as suicidal because of uncontrolled pain. She
24 stated her pain was 9 out of 10 and the methadone dosage was "not enough". Respondent
25 referred Patient P-1 to John Muir Behavioral Health Center but she started experiencing shortness
26

27 ⁸ Promethazine-codeine syrup is a prescription medicine used to temporarily treat cough
28 and upper respiratory symptoms. It is a Schedule V controlled substance, and, if taken in
conjunction with benzodiazepines, or other central nervous depressants, including alcohol, can
cause severe drowsiness, breathing problems (respiratory depression), coma and death.

1 of breath and was denied admission without a medical clearance by Respondent. Respondent
2 spoke with Patient P-1 on January 4, 2012 regarding her cough and to discuss her breathing
3 troubles/bronchitis/wheezing. On January 5, 2012, Respondent medically cleared Patient P-1 to
4 be treated at John Muir.

5 16. On January 11, 2012, Patient P-1 called Respondent because the pharmacy requested
6 Patient P-1 ask him for a new prescription for Norco.⁹ On January 11, 2012, Dr. N.F. called
7 Respondent to advise that Patient P-1 fell out of her wheelchair on January 10, 2012 and was
8 walking down the street "totally out of it" and wanted to know whether to stop Depakote¹⁰
9 because Patient P-1 claimed that Depakote caused the problem. The medical records are unclear
10 as to whether Respondent contacted Dr. N.F. to follow-up. On January 15, 2012, Respondent
11 prescribed 180 pills of 10-mg hydrocodone/325 milligram acetaminophen with an MME of 60 per
12 day. On January 16, 2012, Respondent prescribed 600 pills of methadone for 200 milligrams per
13 day with an MME of 2400 per day.

14 17. Patient P-1 was admitted to John Muir hospital from January 24, 2012 to January 28,
15 2012 for respiratory failure secondary to narcotic and benzodiazepine overdose and was in an
16 altered mental status secondary to drug overdose. She was found unresponsive by her son and
17 taken by ambulance to the hospital. Patient P-1 had previously been admitted to John Muir
18 hospital for opioid overdose on "multiple occasions". Patient P-1 had difficulty with her sight but
19 had several large bottles of medication with her in different strengths which was noted to not be a
20 "safe situation" and she was to be followed by a Home Health RN for medication review.
21 Respondent was cc'd on the medical records related to this hospitalization.

22 18. Patient P-1 was discharged from the hospital on January 28, 2012 and on January 31,
23 2012, a home health nurse called Respondent to alert him that Patient P-1 was "taking
24

25 ⁹ Norco is a trade name for hydrocodone bitartrate with APAP (hydrocodone with
26 acetaminophen) tablets. Norco 325/10 reflects that each pill contains 325 mg of acetaminophen
27 and 10 mg of hydrocodone bitartrate. Hydrocodone bitartrate is a semisynthetic narcotic
28 analgesic and a dangerous drug as defined in section 4022 and a Schedule III controlled
substance.

¹⁰ Depakote is the brand name for Valproic Acid and is an anticonvulsant used to treat
seizures and bipolar disorder.

1 medications that she should not be taking” and wanted to discuss possibly getting her a social
2 worker. Respondent called back and left a message per medical records.

3 19. Concord Health Center prescription records show the following prescriptions written
4 by Respondent: on February 7, 2011: Methadone: 10 mg with 120 quantity; on April 11, 2011:
5 Methadone: 10 mg and Oxycodone with Acetaminophen (Percocet)¹¹ 5 mg/325 mg: 90 tabs
6 quantity (one week supply at a time); on April 20, 2011: 180 tabs of methadone 10 mg; on July
7 21, 2011: 180 tabs of 10 mg methadone and 90 tabs of 5 mg/325 mg Percocet; on August 10,
8 2011: 240 tabs of 10 mg methadone and 180 tabs of 10 mg/325 mg Norco; on September 1,
9 2011: 180 tabs of 10 mg/325 mg Norco; on October 5, 2011 480 tabs of 10 mg methadone and
10 180 tabs 10 mg/325 mg Norco; On October 31, 2011 480 tabs of 10 mg refilled by Dr. A.K.;
11 December 19, 2011: 600 tabs 10 mg Methadone, 240 ml 6.25 mg/10 mg promethazine-codeine
12 syrup and 180 tabs of Norco 10 mg/325 mg; in December 28, 2011 240 6.25 mg/10 mg
13 promethazine-codeine syrup; on December 29, 2011: 240 ml 6.25 mg/10 mg promethazine-
14 codeine syrup; January 11, 2012: 600 tabs of 10 mg methadone; 180 tabs Norco 10 mg/325 mg;
15 240 ml promethazine-codeine syrup 6.25 mg/10 mg; January 25, 2012: 240 ml promethazine-
16 codeine syrup 6.25 mg/10 mg. On January 19, 2012 and January 25, 2012, Respondent ordered
17 240 milliliters of Promethazine-Codeine syrup (6.25 mg/10 mg) for Patient P-1. On January 25,
18 2012, Respondent prescribed 180 tablets of Norco (10/325 mg) with one refill remaining.

19 20. Repondent was interviewed on October 11, 2018 regarding his treatment of Patient
20 P-1. Respondent recalled Patient P-1 ran out of methadone in November 2011 and compensated
21 with alcohol and became suicidal and had to be hospitalized. He described her as a “very, very
22 challenging patient.” Respondent admitted considering tapering his patient, however, he did not
23 do so. Respondent also admitted he did not have access to CURES but that he had called the
24 pharmacy to access CURES. Respondent was questioned about the CURES prescription report
25 which showed that he prescribed methadone amounts of 10 milligram, 600 pills in December

26 ¹¹ Percocet is a trade name for Oxycodone and Acetaminophen combined. Oxycodone is
27 an opioid pain medication sometimes called a narcotic and Acetaminophen is a less potent pain
28 reliever that increases the effect of the oxycodone. Oxycodone is a dangerous drug as defined in
section 4022 and a Schedule II controlled substance. It is a more potent pain reliever than
morphine or hydrocodone.

1 2011 and 10 milligram, 600 pills in January 2012 and stated "that does not sound right." These
2 prescription levels were later confirmed from a CVS Pharmacy patient prescription profile that
3 showed that on December 19, 2011, Respondent wrote a prescription for methadone (10
4 milligrams, 600 tabs) and again on January 16, 2012 (10 milligrams, 600 tabs).

5 21. Patient P-1 died on February 5, 2012 and the coroner listed her cause of death as
6 "acute methadone intoxication."

7 **CAUSE FOR DISCIPLINE**

8 **(Unprofessional Conduct: Gross Negligence/Repeated Negligent**
9 **Acts/Incompetence/Improper Prescribing Without an Appropriate Prior Examination and**
10 **Medical Indication)**

11 **(Code Sections 2234(b), (c), and (d); 2242)**

12 22. Respondent is subject to disciplinary action under section 2234, subdivisions (b)
13 (gross negligence), (c) (repeated negligent acts), (d) (incompetence) and 2242 (improper
14 prescribing) in that Respondent has committed gross negligence and/or repeated negligent acts
15 and/or incompetence in the practice of medicine as described above, including, but not limited to,
16 the following:

17 A. Respondent failed to reduce the dosage of opioids prescribed by reassessing the need
18 for opioids every three months and determining if the dosage should be tapered. Respondent
19 stated that he considered tapering Patient P-1 from methadone but instead he increased the dosage
20 and even added additional opiate medication over a period of five months and Patient P-1
21 subsequently died of methadone intoxication.

22 B. Respondent failed to refer Patient P-1 to an addiction or pain specialist despite
23 dosages of greater than 80 morphine milligram equivalents per day. Patient P-1 received 2400
24 morphine milligram equivalents per day without referral to an addiction or pain specialist.

25 C. Respondent failed to take steps to account for, and was unaware of, the amount of
26 narcotics prescribed to Patient P-1. For example, Respondent did not review the state
27 prescription drug monitoring program (CURES) despite Patient P-1 being prescribed opioids.
28 Respondent admitted that he had no access to CURES, however, he called the pharmacy and

1 requested that the pharmacy access CURES, yet Respondent did not appear to understand the
2 amount of medications that Patient P-1 was being prescribed.

3 D. Respondent prescribed Patient P-1 more than one central nervous system depressant
4 in combination. Patient P-1 was treated by multiple clinicians who prescribed a combination of
5 benzodiazepines and opioids and Respondent apparently did not check CURES or take other steps
6 to determine what prescriptions Patient P-1 obtained from other prescribers and failed to limit or
7 taper the combinations of central nervous system depressants.

8 E. Respondent failed to use drug testing before starting opioid therapy for chronic pain,
9 and failed to take other steps to verify the patient's compliance with a treatment plan. For
10 example, Respondent did not consider regular urine drug testing at least annually to assess the
11 combinations being used including other prescribed medications, as well as other controlled
12 prescription drugs and illicit drugs.

13 **PRAYER**

14 WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged,
15 and that following the hearing, the Medical Board of California issue a decision:


16 1. Revoking or suspending Physician's and Surgeon's Certificate Number A 83871,
17 issued to Philipp Leo Bannwart, M.D.;

18 2. Revoking, suspending or denying approval of Philipp Leo Bannwart, M.D.'s authority
19 to supervise physician assistants and advanced practice nurses;

20 3. Ordering Philipp Leo Bannwart, M.D., if placed on probation, to pay the Board the
21 costs of probation monitoring; and

22 4. Taking such other and further action as deemed necessary and proper.

23 DATED:
24 December 17, 2018


KIMBERLY KIRCHMEYER
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant

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28 SF2018501101
Bannwart.phillip.accusation